MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1815

1. PLACE OF DEATH
County: Linn
Township: Wantsville
City: Brookfield Mo
Registration District No. 504
Primary Registration District No. 5667
File No.
Registered No. 3
(No. ..... St. ..... Ward)

2. FULL NAME: Louisa Jane Kennedy
(a) Residence. No. R.F.D. St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmol
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: W. H. Kennedy

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feby 14 - 1849

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

PARENTS
10. NAME OF FATHER: Dorr Lewis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dorr Lewis
12. MAIDEN NAME OF MOTHER: Dorr Lewis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT: Mrs L R Cleveland
(Address) Linneus, Mo.

15. FILED 2-16, 1930 U. C. Dryden REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Jan 27, 1930 that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial
Nephritis
131 Several years
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) J. W. Bierce, M. D
1/28, 1930 (Address) Laclede Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bear Branch Cemetery
DATE OF BURIAL: 1/29/1930

20. UNDERTAKER: Hunter, Rollins
ADDRESS: Brookfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.